SECTION 2

CHEC Services

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1 CHEC SERVICES

The Child Health Evaluation and Care (CHEC) program is Utah's version of the federally mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. CHEC is an integral part of the Medicaid program. There are three main components to CHEC: Prevention, Outreach and Expanded Services. These are addressed in this section of the Utah Medicaid Provider Manual.

For information concerning physician services, injectable medications, non-covered CPT codes, or CPT codes which require Prior Authorization, please refer to the Utah Medicaid Provider Manual for Physician Services, SECTION 2.

Medicaid encourages families to obtain CHEC screenings for children on Medicaid.

1 - 1 Prevention and Outreach

The families of Medicaid eligible children are encouraged to seek early and repeated well-child health care visits for their children. These visits should begin as early as possible, ideally at birth, and continue through the child's 20th birthday. The Utah Department of Health contracts with local health departments to provide outreach services to families. Families are informed of the importance of well-child care and that a visit is due as part of CHEC outreach and education efforts.

1 - 2 Expanded Services

When a Medicaid eligible child requires **medically necessary** services, those services may be covered by Medicaid. Necessary health care, diagnostic services, treatment and other measures described in Section 1905 (a) of the Social Security Act to correct or ameliorate defects, and physical and mental illness and conditions discovered by the screening services are available based on medical necessity. Generally, prior authorization is needed before providing services. Refer to Chapter 3 - 5, Expanded Services: Other Necessary Health Care, for more information on expanded services and a list of some of those services.

Individuals aged 19 through 20 who are enrolled in Non-traditional Medicaid do not qualify for expanded benefits.

1 - 3 Definitions

Utah uses federal definitions for the CHEC program. They are:

E arly means as soon as possible in the child's life.

P eriodic means at intervals established for screening by medical, dental and other health care experts to assure that disease or disability has not appeared since the child's last evaluation. The types of procedures performed and their frequency will depend on the child's age and health history.

S creening is the use of quick, simple procedures carried out among large groups of children to sort out apparently well children from those who may have a disease or abnormality and need more definite study of a possible physical, emotional or developmental problem.

D iagnosis is the determination of the nature or cause of physical or mental disease or abnormality through combined use of health history, physical and developmental examinations and laboratory tests and x-rays.

T reatment means physician or dentist services or any other type of medical care and/or services recognized under state law to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

2 COVERED SERVICES

CHEC covered services include screening preventive, outreach and expanded services.

2 - 1 Screening and Prevention Services

Screening services include all of the following:

1. A comprehensive health and developmental history, including the assessment of physical and mental development and dental/oral health screening;

2. A comprehensive physical examination;

3. Appropriate immunizations according to age and health history;

4. Laboratory tests, including blood lead level assessment appropriate to age and risk; and

5. Health education, including anticipatory guidance.

Each of these screening and prevention services is described more fully in the remainder of Chapter 2. Appendix C, Child Health Evaluation and Care Recommended Schedule, is a quick summary of CHEC requirements. It is provided as a tool and is not intended to replace material in this manual.

2 - 2 Comprehensive History

A comprehensive history, obtained from the parent or other responsible adult who is familiar with the child's history, should include the following two types of history:

1. Developmental history to determine whether the child's individual developmental processes fall within a normal range of achievement according to age group and cultural background.

   We recommend the following screening tools for screening children up to six years of age:

   - Ages and Stages Questionnaire (ASQ)
   - Child Development Review (CDR)
   - Communication and Symbolic Behavior Scales Development Profile - Infants and Toddler (CSBSDP - Infant and Toddler Profile)
   - Infant Developmental Inventory (IDI)
   - Parent's Evaluation of Developmental Status (PEDS)

   Discuss the child's development with the parents. Discuss methods and techniques the parents can use to enhance the child's development. Children born to women enrolled in Medicaid become eligible for a Targeted Case Management service focused on child development. When children are followed by public health nurses, as part of this service, the nurses are instructed to communicate with the child's primary care provider. The nurse will share information about the child which is important in assessing the child's development. You may contact the local health department in your area if you feel a child enrolled in Medicaid should receive or would benefit from Targeted Case Management services.

2. Nutritional history and status by asking questions about dietary practices to identify unusual eating habits, such as pica or extended use of bottle feedings, or diets which are deficient or excessive in one or more nutrients.

3. Complete a dental history.

2 - 3 Comprehensive Physical Examination with screening procedures.

A comprehensive physical examination should include the following:

1. **Physical Examination:** An unclothed and standardized physical examination to evaluate the general appearance of the child and includes an assessment of all body systems. Complete an oral inspection of the mouth, teeth and gums during each CHEC screening.

2. **Height and Weight:** Accurately measure length (0-2 years), height (ages greater than 2 years) and weight. Assess the child's growth and plot measurements on the 2000 CDC growth charts. CDC recommends that the BMI-for-age-charts be used for all children 2 to 20 years of age in place of the weight-for-stature charts. These charts are available at http://www.cdc.gov/growthcharts/. The charts are available in a PDF format which you may download and print for office use. Measure and chart the occipital frontal head circumference (OFC) of each child two years of age and younger.

3. **Vision Screening:** Administer an age-appropriate vision screening. A system using LEA symbols are very easy for younger children to use. The recommended protocols for each age in the following table:

Vision Screening Procedure	Birth to two	Two to Five	Five and over
External inspection for gross abnormalities or obvious strabismus.	✔	✔	✔
Gross visual acuity with fixation test.	✔		
Light sensation with pupillary light reflex test.	✔		
Observation and report of parent.	✔		
Examination of red reflex.	✔	✔	✔
Alternate cover test.		✔	
Corneal Light reflex.		✔	
Visual acuity using the Illiterate Snellen E Chart or the Allen Cards *		✔	
Visual acuity using the Illiterate E or the Snellen Alphabet Chart.			✔
Color Discrimination on all boys.			✔

We recommend further evaluation and proper follow up for the following vision problems:

a. Infants and children who show evidence of enlarged or cloudy cornea, cross eyes, amblyopia, cataract, excessive blinking or other eye normality;

b. a child who scored abnormally on the fixation test, pupillary light reflex test, alternate cover test, or corneal light reflex in either eye;

c. a child with unequal distant visual acuity (a two-line discrepancy or greater);

d. a child under age five years of age with distant visual acuity of 20/50 or worse;

e. a child five years of age or older with distant visual acuity of 20/40 or worse.

4. **Hearing Assessment:** Administer an age appropriate hearing assessment. We have listed recommended protocols for each age in the following table:

Hearing Assessment Procedure	Birth to 6 months	6 months to 4 years	4 years to under 21 years	See Table Footnotes
Newborns will be screened using physiological techniques, such as auditory brainstem response (ABR), otacoustic emissions (OAE) or a similarly objective procedure approved by the Utah Department of Health.	✔			1, 2
Medical history, physical and developmental assessment.	✔	✔	✔	
Middle ear examination by otoscopy.	✔			
Middle ear examination by otoscopy and/or acoustic impedance.		✔	✔	
Screen using age appropriate behavioral techniques provided by or under the supervision of a state licensed audiologist. Visual response audiometry (VRA), conditioned orientation response (COR) or play audiometry is required. ABR and OAE screening may also be used.		✔		2, 3, 4
Conventional bilateral puretone screening under earphones.			✔	2, 3, 4

Table Footnotes

1. Newborns will be screened in the birthing hospital before discharge when screening is available at that hospital. When these services are not available in the hospital, hearing screening should take place as soon as possible after birth.
2. Screening should be supervised by a state licensed audiologist.
3. The marked hearing screening exam should be done on all children at the initial CHEC screening when the child enters the program for the first time.
4. Perform at least once based on the child's age. Perform more frequently if historical findings or presence of risk factors indicate. In this case, perform the exam at each periodic visit.

Infants with the following indicators require hearing evaluation every six (6) months until 3 years of age and at appropriate intervals thereafter:

a. Parental or care giver concern regarding hearing speech, language and or developmental delay.

b. Family history of permanent childhood hearing loss.

c. Stigmata or other findings associated with a syndrome known to include a sensorineural or conductive hearing loss or eustachian tube dysfunction.

d. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis.

e. In utero infections such as cytomegalovirus, herpes, rubella, syphilis, and toxoplasmosis.

f. Neonatal indicators - specifically hyperbilirubinemia at a serum level requiring exchange transfusion, persistent pulmonary hypertension of the newborn associated with mechanical ventilation and conditions requiring the use of extracorporeal membrane oxygenation (ECMO).

g. Syndromes associated with progressive hearing loss such as neurofibromatosis, osteopetrossis, and Usher's syndrome.

h. Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Fridreich's ataxia and Charcot-Marie-Tooth syndrome.

i. Head trauma.

j. Recurrent or persistent otitis media with effusion for at least 3 months.

5. **Speech and Language Development:** Screen for appropriate speech and language development to identify delays in speech and language development.

   a. The following expressive landmarks in speech and language development are offered as guidelines for the speech and language screening:

      * At six months a child babbles and initiates social approach through vocalization;
      * At one year a child says 'mama' and 'dada' specifically and engages in vocal play;
      * At two years a child begins connecting words for a purpose, such as 'me go' and 'want cookie';
      * At three years a child holds up her fingers to show her age and has a vocabulary of 500-1,000 words. She will use an average of three to four words per utterance;
      * At four years a child's speech should be 90% intelligible. He may make some articulation errors with letters s, r, l, v. He should use a minimum of four to five words in a sentence.

   b. Refer the child for a speech and hearing evaluation if you observe one or more of the following:

      * the child is not talking at all by age 18 months;
      * you suspect a hearing impairment;
      * the child is embarrassed or disturbed by his own speech;
      * the child's voice is monotone, extremely loud, largely inaudible, or of poor quality;
      * there is noticeable hyper nasality or lack of nasal resonance;
      * the parent(s) express concern about the child's speech and/or hearing development;
      * the child fails the screening tests;
      * recurrent otitis media;
      * speech is not understandable at age four years, especially in cases of suspected hearing impairment or severe hyper nasality.

6. Measure the blood pressure of all children three years and older at each CHEC screening. Chart the child's blood pressure on the Age-Specific Percentiles of Blood Pressure of Children. These charts are available from the Utah Department of Health, Bureau of Chronic Disease, Hypertension Control Program. Telephone: (801) 538-6141

   The child's blood pressure is abnormal if the systolic and/or diastolic are above the 95th percentile. Measure the child's blood pressure again in 7 to 14 days if the reading is above the 95th percentile.

2 - 4 Age Appropriate Immunizations

Assess whether the child has been appropriately immunized against diphtheria, pertussis, tetanus, polio, Hepatitis B, measles, rubella, mumps, chicken pox and Hib. Obtain a careful and accurate immunization history by talking with the parent(s) or guardian(s) and reviewing available history and/or records. Determine if any immunizations are needed. Give the child the appropriate immunizations or refer the child to the local health department to obtain needed immunizations. The immunization schedule may be obtained at http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable. Give immunizations as listed in Appendix B, Immunization Schedule.

2 - 5 Appropriate Laboratory Tests

Conduct appropriate laboratory tests. Use your medical judgement to determine the applicability of specific laboratory tests or analyses for each child. Perform the following laboratory tests at the time of the CHEC screening. Follow the recommendation of the American Academy of Pediatrics to determine the specific periodicity of each of the following tests.

1. Newborn Metabolic Disease Screening

   Follow the rules in UCA R398-1 to perform Newborn Screening for Metabolic disorders (Phenylketonuria, Galactosemia, Congenital Hypothyroidism). Assist the family with appropriate follow-up tests.

2. Hematocrit or Hemoglobin Screening.

   The erythrocyte protoporphyrin (EP) test is a simple, cost effective tool for screening iron deficiency. The Public Health Service recommends use of this test when possible. You may use hemoglobin concentration or hematocrit where the EP test is not available.

3. Tuberculin Screening

   Follow the American Academy of Pediatrics Committee on Infectious Disease recommendation for annual tuberculin testing of high risk children.

   Children at high risk include:

   - ✔ American Indian and Alaskan native children;
   - ✔ children living in neighborhoods where the case rate is higher than the national average;
   - ✔ children from, or whose parents have immigrated from Asia, Africa, the Middle East, Latin America or the Caribbean; and
   - ✔ children in households with one or more cases of tuberculosis.

4. Cholesterol Screening

   Cholesterol screening is at the discretion of the physician based on risk level of the child.

5. Lead Toxicity Screening

The Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend a lead risk assessment and a blood lead level test for all Medicaid eligible children between the ages of 6 and 72 months. This component of the CHEC screening is mandated by federal rules. **All children ages 6 to 72 months of age are considered at risk for lead poisoning and must be screened.**

✔ Complete a verbal risk assessment for all Medicaid-eligible children ages six to 72 months at each CHEC screening.

✔ Complete a blood lead level test for children at 12 and 24 months, any time from 24 to 72 months when the child has not had the test, or whenever the verbal assessment indicates the child is at high risk for lead poisoning. If a child has not received a blood lead level test, that child must receive it immediately, whether classified high or low risk based on the verbal assessment.

A. Verbal Risk Assessment

Beginning at six months of age, a verbal risk assessment must be performed at every CHEC visit. At a minimum, the following types of questions must be asked to determine the child's risk for lead exposure:

- Does your child live in or regularly visit a house built before 1978? Was his or her child care center/preschool/babysitter's home built before 1978? Does the house have peeling or chipping paint?
- Does your child live in a house built before 1978 with recent, ongoing or planned renovation or remodeling?
- Have any of your children or their playmates had lead poisoning?
- Does your child frequently come in contact with an adult who works with lead? (Examples are construction, welding, pottery, or other trades practiced in your community.)
- Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? (Give examples in your community.)
- Do you give your child any home or folk remedies that may contain lead?
- Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
- Does your home's plumbing have lead pipes or copper with lead solder joints?

You may ask the parent to complete the form in Appendix D, Lead Toxicity Risk Assessment, then review the answers with the parent.

B. *Low Risk for Lead Exposure*

If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. Children at low risk for lead exposure must receive a blood lead test at 12 and 24 months.

C. *High Risk for Lead Exposure*

If the answer to any question is positive, a child is considered at high risk for high doses of lead exposure and a blood lead level test must be obtained immediately regardless of the child's age.

Subsequent verbal risk assessments can change a child's risk category. If, as a result of a verbal risk assessment a previously low risk child is re-categorized as high risk, that child must be given a blood lead level test.

D. Reportable Blood Lead Levels

Blood lead level samples may be capillary or venipuncture. A blood lead test result equal to or greater than 10 ug/dL obtained by capillary specimen must be confirmed using a venous blood sample. In accordance with the Utah Injury Reporting Rule (R386-703), all blood lead levels equal to or greater than 15 ug/dL must be reported to the Utah Department of Health, Bureau of Epidemiology which maintains a blood lead registry. Reports of children with blood lead levels of 20 ug/dL or greater will be shared with the Utah Department of Health, Bureau of Environmental Health Services.

E. Blood Lead Level Test Kits

You may arrange for blood lead analysis with any Medicaid enrolled lab certified to perform blood lead analysis.

F. *Codes for blood lead level test*

CHEC providers may use CPT code 36415 when submitting claims for venipuncture blood lead specimen collection for CHEC eligibles. Capillary blood specimen collection for blood lead testing may be billed using CPT code 36416, but only for CHEC eligibles ages 0 to 24 months.

Do not bill code Y1495 for completing the lead survey, as this form is no longer required.

6. Other Tests

Consider other tests based on the appropriateness of the test. Take into account the individual's age, sex, health history, clinical symptoms and exposure to disease.

2 - 6 Health Education

Health education is a required component of screening services and includes anticipatory guidance. Provide health education and counseling to both parents (or guardians) and children. Provide health education and counseling information about:

✓ understanding what to expect in terms of the child's development and techniques to enhance a child's development;

✓ the benefits of healthy lifestyles and practices;

✓ accident and disease prevention;

✓ injury prevention;

✓ nutrition counseling.

3 OTHER SERVICES

Other CHEC services include vision, dental, hearing, mental health services and "expanded services" which are prior authorized by Medicaid.

3 - 1 Vision Services

Vision services, at a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. When needed, refer the child to the appropriate specialist. Refer to the Utah Medicaid Provider Manual for Vision Care Services, SECTION 2, for policy on services.

3 - 2 Dental Services

Every child should begin to receive oral health risk assessments by six months of age by a pediatrician or other qualified pediatric health care provider. Dental services for children, at a minimum, include preventive dental services such as preventive dental examinations, prophylaxis, topical fluoride applications, appropriate prescriptions for fluoride supplements, fluoride treatments and sealants. In addition, the following services are included: relief of pain and infections, restoration of teeth and maintenance of oral health. Orthodontic Treatment is provided in cases of severe malocclusions and requires prior authorization. See the Utah Medicaid Provider Manual for Dental Care Services, SECTION 2, for policy on services.
Refer the child to a dentist as follows:

* Make the initial referral by six months of age, if determined necessary by a pediatrician, and yearly thereafter;
* Make the referral if the child is at least four years and has not had a complete dental examination by a dentist in the past 12 months;
* Make the referral at any age if the oral inspection reveals cavities, infection, or significant abnormality.

A. Optional Dental Services

1. Fluoride varnish reduces the incidence of dental caries by approximately 40% compared to other preventative treatments. It is a lacquer-based product containing fluoride (5 percent sodium fluoride (NaF) or 22,600 ppm of fluoride) applied topically to the teeth. Fluoride varnish sets on contact with intraoral moisture, so thorough drying prior to application is not required. Application time runs from one to four minutes, depending on the number of teeth within the oral cavity. Varnish may be applied with any convenient applicator (e.g., a disposable brush or cotton-tipped applicator, or the syringe-type applicator included with the product). Fluoride varnish minimizes the risk of inadvertent fluoride consumption and is easy to use on very young children. It forms a deposit on the dental enamel that slowly releases a high concentration of fluoride ions into the dental enamel. It is effective in preventing tooth decay and remineralizes tooth damage caused by the decaying process. Fluoride varnish may be applied to a child's teeth at regular 4 to 6 month intervals starting with primary eruption and continuing through age 3.

   Medicaid will pay for application of dental fluoride varnish as an optional service for children birth through 3 years as part of a well-child (CHEC) exam. Claims for the application of dental varnish must be submitted using the appropriate EPSDT CPT code (see section 4-2 for a list of the codes) for the corresponding visit with an EP modifier to indicate the application of fluoride varnish during the visit. For more information, training, or technical advice on the application of the varnish, contact the Oral Health Program at the Utah Department of Health (801) 538-9177. For more information related to claims, payments, or billing codes contact Medicaid Information at (801) 538-6155.

Note: Appendix A, Child Health Evaluation and Care Recommended Dental Periodicity Schedule, is a quick summary of CHEC dental periodicity requirements. The schedule has been adopted from the Academy of Pediatric Dentistry's recommendations for dental services for the target population (age 0-21) of children. This schedule is provided as a tool and is not intended to replace material in this manual. Appendix A can be found in the CHEC Services - Appendices as an attachment to this manual.

3 - 3 Hearing Services

Hearing services, at a minimum, include diagnosis and treatment for defects in hearing, including hearing aids. When needed, refer the child to an appropriate specialist. Refer to the Utah Medicaid Provider Manual for Audiology Services, SECTION 2, for policy on services.

Infants with the following indicators require hearing evaluations every six months until 3 years of age and at appropriate intervals thereafter:

1. Parental or care giver concern regarding hearing speech, language and or developmental delay.

2. Family history of permanent childhood hearing loss.
3. Stigmata or other findings associated with a syndrome known to include a sensorineural or conductive hearing loss or eustachian tube dysfunction.
4. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis.
5. In utero infections such as cytomegalovirus, herpes, rubella, syphilis, and toxoplasmosis.
6. Neonatal indicators - specifically hyperbilirubinemia at a serum level requiring exchange transfusion, persistent pulmonary hypertension of the newborn associated with mechanical ventilation and conditions requiring the use of extracorporeal membrane oxygenation (ECMO).
7. Syndromes associated with progressive hearing loss such as neurofibromatosis, osteopetrossis, and Usher's syndrome.
8. Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Fridreich's ataxia and Charcot-Marie-Tooth syndrome.
9. Head trauma.
10. Recurrent or persistent otitis media with effusion for at least 3 months.

3 - 4 Mental Health Services

Services that support young children's healthy mental development can reduce the prevalence of developmental and behavioral disorders which have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems. Broadly defined, screening is the process by which a large number of asymptomatic individuals are evaluated for the presence of a particular trait that may be indicative of a behavioral developmental issue. Screening tools offer a systematic approach to this process. Ideally, tools that screen for the mental development of young children should:

- help to identify those children with or at risk of behavioral developmental problems,
- be quick and inexpensive to administer,
- be of demonstrated value to the child and family and provide information that can lead to action,
- differentiate between those in need of follow-up and those for whom follow-up is not necessary, and
- be accurate enough to avoid mislabeling many children.

Screen the child for possible mental health needs. You may use a standardized behavior checklist to do this screen. We recommend the following social emotional tools for screening infants 0-12 months:

- Ages and Stages Questionnaire (ASQ) http://www.brookespublishing.com/store/books/squires-asqse/index.htm
- Ages and Stages Questionnaire: Social Emotional (ASQ:SE) http://www.brookespublishing.com/store/books/squires-asqse/index.htm
- Parent's Evaluation of Developmental Status (PEDS) http://www.pedstest.com
- Temperament and Atypical Behavior Scale (TABS) http://www.pbrookes.com/store/books/bagnato-tabs/faqs.htm

Screening accompanied by referral and intervention protocols can play an important role in linking children with and at-risk for developmental problems with appropriate interventions.

Medicaid encourages providers to refer children with suspected mental health needs for mental health assessment. Refer the child to the mental health provider listed on the Medicaid Identification Card. If no provider is listed on the Medicaid Card, refer the child to a Medicaid Mental Health Provider in the child's home area. Mental Health Services, at a minimum, include diagnosis and treatment for mental health conditions. Refer to the Utah Medicaid Provider Manual for Mental Health Services, Section 2, for policy on services.

Maternal Depression Screening

Maternal Depression is extremely common in Utah. In fact, Utah registers one of the highest rates of depression in the country, as cited in the *Utah Health Status Update*, April 2006. Over time, children raised in a home with a depressed parent run a greater risk of developing behavioral problems and depression. Because maternal depression can have a strong impact on parenting and child outcomes, primary care health providers can contribute to their pediatric patients' health and support by screening and assisting mothers with referrals for depression.

Screen the child's mother for possible depression. We recommend the following validated tools for screening mothers of infants 0-12 months:

- 2-question Patient Health Questionnaire (PHQ-2) http://www.depression-primarycare.org/ or http://www.pfizer.com/pfizer/download/do/phq-9.pdf
- 9-question Patient Health Questionnaire (PHQ-9) (see above)
- Edinburgh http://www.dbpeds.org/articles/detail.cfm?TextID=485
- Beck Depression Inventory-II (BDI-II) Psychological Corporation
- Family Psychosocial Screen (FPS) http://pedstest.com/content.php?content=download_resources.html

We suggest screening for maternal depression at:

- During the hospital stay (3-7 days after birth)
- 2 week Well-Child Visit (WCV)
- 2 month Well-Child Visit (WCV)
- Brief maternal depression screening conducted during a WCV is feasible and identifies mothers willing to discuss depression and stress issues with their child's pediatrician or health care provider.

Action steps for mothers screening positive for depressive symptoms:

- Referral to a mental health provider, using appropriate resources
- Non-judgemental discussion of impact of depression on their child
- Follow-up with phone call or a later visit

Screening accompanied by referral and intervention protocols play an important role in linking depressed mothers with appropriate interventions.

Medicaid encourages providers to refer depressed mothers with suspected mental health needs for mental health assessments.

Refer the child's mother to the mental health provider listed on the Medicaid Identification Card. If no provider is listed on the Medicaid Card, refer the child's mother to a Medicaid Mental Health Provider in the child's home area. Mental Health Services, at a minimum, include diagnosis and treatment for mental health conditions. Refer to the Utah Medicaid Provider Manual for Mental Health Services, Section 3, for policy on services.

3 - 5 Expanded Services: Other Necessary Health Care

Generally, Medicaid does not reimburse non-covered procedures. However, other necessary health care, diagnostic services, treatment and other measures described in Section 1905 (a) of the Social Security Act to correct or ameliorate defects, and physical and mental illness and conditions discovered by the screening services are available based on medical necessity. Such exceptions are considered through the Prior Authorization process.
Prior Authorization (PA) confirms that services requested are needed, that they conform to commonly accepted medical standards, and that all less costly or more conservative alternative treatments have been considered. Medicaid Prior Authorization requirements apply ONLY for services to be provided for a patient assigned to a Primary Care Provider or **not** enrolled in a managed care plan. The Prior Authorization process described in this chapter applies for services which may be covered directly by Medicaid because the services are not included in a contract with a managed care plan. For more information about the Prior Authorization Process, please refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 9, Prior Authorization Process.

Prior Authorization Process

Prior Authorization for services is granted by the child's health maintenance organization (HMO), when the child is enrolled or by Medicaid when the child is not enrolled in an HMO. When the child is enrolled in an HMO, follow procedures outlined by that organization for prior authorization.

When you discover a need for further services which will require Prior Authorization and the child is not enrolled in an HMO, follow the process described.

Prior Authorization requests for Child Health Evaluation and Care (CHEC) services not typically covered by Medicaid must be submitted on Utah SDH-DHCF Form 18 and include the following information:

a. The estimated cost for the service or item;

b. A photocopy of any durable medical equipment item(s) requested;

c. A current comprehensive evaluation of the child's condition, completed by the appropriate therapist, that includes the diagnosis, general medical history, therapy treatment history, age, height, weight, capabilities, prognosis, specific limitations, and the purpose for any durable medical equipment that is requested;

d. A letter from the physician describing medical necessity and including the diagnosis, the medical reason for the request, the medical condition that justifies the request, and the portion of the medical history that applies to the specific request. The letter must be patient specific, indicate the reasons the physician is recommending the service or equipment, and whether the service or equipment would contribute to preventing a future medical condition or hospitalization.

The physician making the request, the therapist and the provider should communicate directly and work as a team to evaluate the most appropriate services for the child.

Send written requests to:

MEDICAID PRIOR AUTHORIZATION
BOX 143103
SALT LAKE CITY UT 84114-3103

Prior Authorization requests may be sent via FAX to 1-801-538-6382, attention "Prior Authorizations."

For additional information, call Medicaid Information:

In the Salt Lake City area, call **538-6155**

Call toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado **1-800-662-9651**

From all other areas **1-801-538-6155**

Press **3** for the Provider menu and follow menu instructions.

4 REIMBURSEMENT

The CHEC screening fee includes payment for all components of the CHEC Screening. Additional services, such as administration of immunizations, laboratory test and other diagnostic and treatment services, may be billed in addition to the CHEC screening. Reimbursement for these services for a child enrolled in an HMO is based on the provider's agreement with the HMO.

4 - 1 Billing for CHEC Exams

Submit claims for the CHEC exam and any additional services to the CHEC population as for any other health care claim. Effective July 01, 1994, the CHEC/Well-Child Conference screening form was no longer required for billing CHEC exams. The Division of Health Care Financing continues to accept claims submitted on this form, but no longer prints nor provides the form.

4 - 2 Instructions for Entering Procedure Code When Billing for a CHEC Exam

To report a CHEC screening, enter the appropriate CPT procedure code listed below on the claim. On an electronic claim, enter the code in the field titled '*Procedures, Services, Supplies*.' On the CMS-1500 paper claim, use Box 24 D, which is titled *'Procedures, Services, or Supplies*.'

Preventive Medicine Services

New Patient

99381 -- infant - less than 1 year of age

99382 -- early childhood - age 1 through 4 years

99383 -- late childhood - age 5 through 11 years

99384 -- adolescent - age 12 through 17 years

99385 -- young adult - age 18 through 20 years

Established Patient

99391 -- infant - less than 1 year of age

99392 -- early childhood - age 1 through 4 years

99393 -- late childhood - age 5 through 11 years

99394 -- adolescent - age 12 through 17 years

99395 -- young adult - age 18 through 20 years

Other

99431 -- history and examination of new born infant

99432 -- normal newborn care in other than hospital or birthing room setting

While these CPT codes refer to a healthy child, we encourage you to use these codes each time you complete a CHEC screening even if the child presents with a chronic illness and/or other health problems.

Medicaid must track the number of children referred for follow-up services. If you discover a problem(s) or condition(s) which require follow-up, **enter 'CF' (CF stands for CHEC Follow-up) in the modifier field** after the CPT code. On an electronic claim, enter the modifier in the field titled '*Procedures, Services or Supplies- Modifier*' after the CPT code. On the CMS-1500 paper claim, enter the modifier in the right hand column of Box 24 D under '*Modifier*'.

It does not matter whether you refer the child to another provider or do the follow-up yourself. This will also enable the Department of Health to track a child who requires additional services and to make certain that the family receives needed assistance in getting the follow-up service.

4 - 3 Children Enrolled in Managed Care Health Plans

Note: Information on billing and Prior Authorization applies to children not enrolled in a managed care health plan. Look at the child's Medicaid Identification card to determine if child is enrolled in a managed care health plan and with which plan the child is enrolled. (If card is not available, use AccessNow, Medicaid On-Line, or call Medicaid Information to obtain the information. Refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 5, *Verifying Eligibility*, for more information.)

Children enrolled in health plans must also receive CHEC screening services. However, billing and authorization for expanded services must be obtained through the plan listed on the child's card.

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